POC #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445190	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HOUSE, THE	250 BELLEBROOK RD BRISTOL, TN 37620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and complaint investigation #31874, was conducted from January 21, 2014, to January 23, 2014, at The Cambridge House. Deficiencies were cited in relation to complaint #31874 under 42 CFR PART 483.13, Requirements for Long Term Care Facilities.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. Administrator and DON were informed that although TBI and APS had received and reported the allegation to the TN. Dept. of Health, the facility also needed to report the incident for Resident #104. The administrator and DON will comply with this requirement from 1/22/14 going forward. 2. The Cambridge House abuse policy will be followed any time a resident, family member, employee or outside agency notifies the facility of allegation of abuse from 1/22/14 going forward.	1/22/14 1/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Shawn Reid | Adm. | 2/14/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to report an allegation of abuse to the State Survey Agency for one resident (#104) of twenty-three residents reviewed. The findings included: Medical record review revealed resident #104 was admitted to the facility on October 1, 2012, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Hypertension, Altered Mental Status, Anxiety and Anemia. Medical record review of the quarterly Minimum Data Set (MDS), dated December 13, 2013, revealed the resident scored a four on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired, required extensive assistance with activities of daily living and was frequently incontinent of bowel and bladder. Further review revealed the resident had the presence of skin tears. Review of the facility's Abuse Program: Investigation/Reporting/Response, dated August, 1999, revealed "...(3) Documentation	F 225	3. Administrator and DON have each reviewed the facility policy regarding abuse and will follow this policy for any allegation received in the future. 4. Any allegations of abuse will be presented to the QIP/QA committee at their regular monthly meeting X3 months and presented by the Administrator or DON to the quarterly meeting of the QA committee to ensure that abuse policy has been followed regarding notification of officials.	1/22/14 2/10/14

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F 225	Continued From page 2 Requirements: written reports to the State Health Department and other required regulatory agencies summarizing the incident, investigation results and facility actions taken to protect the resident(s) and prevent a similar occurrence. This report is to be completed per the guidelines of individual state reporting requirements..." Review of the facility Policy and Procedure for Reporting Suspected Crimes Under the Federal Elder Justice Act, dated July 12, 2011, revealed "...this facility on behalf of staff will file a report to SSA and local law enforcement ...when staff becomes aware of a suspicion of a crime..." Interview with Licensed Practical Nurse (LPN) #1 on January 22, 2014, at 3:25 p.m., in the conference room, revealed "...about eight months ago I spoke with a Tennessee Bureau Investigator (TBI) and someone from the state about (named resident) and an allegation related to a resident getting up from the wheelchair and suffering a laceration to the resident's leg..." Interview with LPN #2 on January 22, 2014, at 4:00 p.m., in the conference room, revealed "...a TBI agent and state worker came to the facility back some time ago and spoke with me ...they asked me about making a comment to resident #104..." Interview with the Director of Nursing on January 22, 2014, at 4:40 p.m., in the conference room, revealed "...the TBI and Adult Protective Services (APS) came to the facility back in June 2013, and reported an allegation that one of our nurses had made a statement to one of the residents and another nurse had mistreated the resident causing a skin tear...we were not aware of any	F 225		

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F 225	Continued From page 3 allegations..." Further interview revealed "...there was an occurrence report filled out in regard to the wound on the leg, it was determined the wound was an old wound and the wound had not occurred due to any mistreatment of the resident..." Interview with the Administrator on January 22, 2014, at 4:55 p.m., in the conference room revealed, "...we did not report the incident to the state Department of Health...the TBI agent stated they would call Nashville...we gave all of our reports to the TBI and did not keep a copy for ourselves..."	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	1. Care Plan for Resident #160 was updated on 1/23/14 to reflect that no needlesticks or BPs were to be taken in the left arm. 2. One other resident is currently receiving dialysis and was admitted on 1/31/14. Care plan, ADL sheets and MAR all reflect that no needlesticks or BPs are to be taken in the right arm.	1/23/14 ~~1/31/14~~ 3/10/14 Jap

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to update the care plan for one resident (#160), of twenty-three residents reviewed. The findings included: Resident #160 was admitted to the facility on November 8, 2013, with diagnoses including Chronic Kidney Disease, Renal Dialysis, Diabetes, Hypertension, and Late Effect of Cerebral Vascular Disease. Medical record review revealed the resident received dialysis three days per week at an out-patient clinic. Continued medical record review revealed the resident had a permanent dialysis access placed in the left arm on January 16, 2014. Observation and interview with the resident on January 23, 2014, at 8:55 a.m., in the hallway, revealed the resident had been on dialysis approximately three months. Continued interview revealed the resident had a permanent access in the left arm. Medical record review of the care plan updated January 16, 2014, revealed the care plan did not address the resident's dialysis access located in the left arm or the practice which requires no needle sticks or blood pressure checks in the arm of the dialysis access. Interview Registered Nurse supervisor on January 23, 2014, at 12:45 p.m., at the nurses'	F 279	3. Licensed personnel were in-serviced by the DON regarding Care Plan Shunt precautions for dialysis patients upon their admission. 4. DON and/or designee will monitor any future dialysis admissions for care plan compliance. Results of audits will be presented to QIP/QA committee at their regular monthly meeting x3 months and presented to the QA committee at the regular quarterly meeting.	~~2/7/14~~ 3/10/14 Sup 2/14/14

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F 279	Continued From page 5 station, confirmed the care plan had not been updated to address the care of the dialysis access.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to monitor the blood pressure for one resident (#2), who was receiving an antihypertensive medication, of twenty-three residents reviewed. The findings included: Medical record review revealed resident #2 was admitted to the facility on September 17, 2013, with diagnoses including Dementia, Psychosis, Senile Dementia, Hypertension, Esophageal Reflux, Anxiety and Anemia. Medical record review of the quarterly Minimum Data Set (MDS), dated December 11, 2013, revealed the resident scored a three on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired and required extensive assistance with the activities of daily living. Medical record review of the Medication Administration Record (MAR) revealed the	F 281	1. Vital signs were immediately taken for Resident #2. BP, T, PR, and O2 sats were all within normal limits. 2. All medication Administration records will be reviewed by DON, RN Unit Managers and Staff Development RN. Any resident receiving medications for Hypertension will have BP taken and recorded on resident's MAR prior to med being given. A space on the MAR will be designated to record the BP.	1/23/14 ~~1/31/14~~ 3/10/14 Dx

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F 281	Continued From page 6 resident was receiving Atenolol (medication for high blood pressure) 25mg (milligrams) by mouth every day. Medical record review of a Nurse's Note, dated December 3, 2013, revealed the resident's vital signs were the following: Pulse 76; Respirations 20, and Blood pressure 124/68. Continued medical record review revealed the resident's blood pressure was not recorded in the medical record after December 3, 2013. Medical record review of the resident's Care Plan, dated September 25, 2013, revealed "...potential for complications r/t (related to) diagnosis ...hypertension...monitor v/s (vital signs) per protocol and PRN (as needed)..." Interview on January 23, 2014, at 11:00 a.m., with Licensed Practical Nurse (LPN) #1, on the West Wing Hallway, revealed "...the residents vital signs are taken at least weekly and recorded on the weekly Nurse's Note...the last vital signs recorded for the resident was on December 3, 2013, and the resident is receiving a blood pressure medication..." Interview on January 23, 2014, at 1:25 p.m., with the West Wing Charge Nurse, in the Director of Nursing office, confirmed the resident's blood pressure had not been obtained since December 3, 2013, and the resident was receiving Atenolol for hypertension. Continued interview confirmed the resident's blood pressure should be obtained at least weekly and documented in the medical record.	F 281	3. Licensed personnel were in-serviced by the DON to monitor and record BPs on MARS for any resident receiving meds for hypertension. A space will be provided on the MAR for recording BP. This will be a continuous process going forward 4. DON and/or designee will randomly audit 25% of charts for compliance with recording BP for residents receiving anti-hypertensives. Results will be reported to the QIP/QA committee at the regular monthly meeting x3 months and presented by the DON at the quarterly regular meeting of the QA committee.	~~2/7/14~~ 3/10/14 Sux 2/14/14
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 8 or turkey (2 days)...fish and seafood (1 day)..." Interview with the dietary supervisor on January 21, 2014, at 10:50 a.m., in the kitchen, confirmed the cottage cheese, tuna salad, ham salad, and Pimento Cheese had expired and were available for serving to the residents.	F 371	3. A daily log was initiated and will be checked daily by the Dietary Manager or the Kitchen Manager to ensure that the refrigerators are checked every morning by a Dietary Dept. designee. Any foodstuffs that are dated for that day's expiration will be disposed of. The log will be signed by the person inspecting the refrigerators. An in-service for the dietary employees was done by the Dietary Manager to educate on the importance of dating and observing dates of preparation and expiration. 4. Daily logs will be kept and a report will be presented by the Dietary Manager at the regular monthly meeting of the QIP/QA committee X 3 months and a report to the QA committee at its regular quarterly meeting.	~~1/22/14~~ 3/10/14 JMC 2/14/14